

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/12/2016
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NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 4, 5, 6, 7, 8, 11 and 12, 2016</p> <p>Facility number: 000112 Provider number: 155205 AIM number: 100288710</p> <p>Census bed type: SNF: 37 SNF/NF: 131 Total: 168</p> <p>Census payor type: Medicare: 15 Medicaid: 100 Other: 53 Total: 168</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 14454 on January 20, 2016.</p>	F 0000	<p>F000 Initial Comments</p> <p>This plan of correction constitutes Greencroft Healthcare's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission or that a deficiency exists, or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. We respectfully request a desk review of this Plan of Correction.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0223 SS=D Bldg. 00	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to prevent mistreatment of a Resident. This affected 1 of 18 residents interviewed (Resident #211).</p> <p>Findings include:</p> <p>During an interview with alert and oriented Resident #211, conducted on 01/07/16 at 3:00 P.M., the resident indicated a staff member had a "bad attitude" and had told him to stop requesting things from staff because he/she was "bothering" them (staff).</p> <p>On 01/08/16 at 11:33 A.M., a review of the clinical record for Resident #211 was conducted. Resident #211 was admitted on 04/07/15. The resident's diagnoses included, but were not limited to, altered mental status, muscle weakness, lack of coordination, difficulty in walking, dysphasia oropharyngeal phase, diabetes without complications type 2, essential hypertension, atrial fibrillation,</p>	F 0223	F0223 There were no further incidence or complaints from resident 211. Resident 211 has voiced satisfaction with care. Resident Council minutes were reviewed for complaints of issues related to care. CNA 6 was suspended during investigation of the incident per facility policy and was reported to ISDH. CNA involved was suspended, counseled, and reinstated. CNA was referred to employee assistance program and completed additional-services related to abuse and communication. Facility uses ABQIS program and 24 hour report sheet to monitor resident satisfaction. Concerns or issues identified are reported to the Administrator immediately and investigated for further action. The Abuse Investigation policy was reviewed(Attachment A). All staff members were in serviced and re educated on abuse reporting policy to notify the immediate supervisor of any complaints. The supervisor will immediately notify the	02/01/2016	

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	<p>polyneuropathy in diabetes and esophageal reflux.</p> <p>On 1/11/16 at 10:00 A.M., an investigation report was reviewed. The report indicated that on 1/8/2016, Resident #211 had alleged that a CNA #6 (Certified Nursing Assistant) forced him to use a mechanical lift and told him if he did not stop screaming he would have to leave. The report further alleged the CNA put her hand on his mouth and told him to be quiet. The Investigation report indicated the incident had occurred on 1/7/16 at 2:01 PM.</p> <p>During an interview, on 01/12/16 at 2:44 P.M., CNA #7 indicated that she was assisting CNA #6 to transfer Resident #211 to his recliner. Resident #211 began "screaming." CNA #7 indicated that CNA #6 covered Resident #211's mouth and indicated that if he did not stop screaming he would have no where else to go. CNA #7 further indicted that CNA #6 began hitting Resident #211 on the chest and telling him to "stop."</p> <p>On 01/04/16 at 11:00 A.M., the Administrator provided the current abuse policy, dated 08/2015. The policy indicated "...Greencroft Healthcare shall not permit residents to be subjected to abuse by anyone, including employees,</p>		<p>Administrator or designee if the Administrator is not available. Nursing staff will communicate any alleged abuse/complaints to their Nurse Team Leader or designee immediately. The NTL or designee will be responsible to notify the Administrator or designee immediately. On weekend and holidays all staff will report to the nurse on call, who will in turn immediately notify the Administrator and DON. The DON or designee will review/audit the 24 hour report sheets daily for complaints from residents. The Administrator or designee will initiate appropriate reporting, investigation, and interventions from protection of harm. These interventions will be communicated with the physician, family, and staff. This is an on going basis. The DON or designee will report findings to QAPI committee at least monthly for review, recommendations, and tracking. Alleged date of compliance 2/1/2016</p>				

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F 0225 SS=D Bldg. 00	<p>other residents, consultants, volunteers, staff or personnel of other agencies serving the resident, family members, legal guardians, sponsors, friends or other individuals...."</p> <p>3.1-27(b)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly</p>			

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	<p>investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to report 1 of 4 allegations of abuse reviewed to the Administrator in a timely manner.</p> <p>Finding includes:</p> <p>On 01/08/2016 at 11:33 A.M., a review of the clinical record for Resident #211 was conducted. Resident #211 was admitted on 04/07/2015. The diagnoses included, but were not limited to, altered mental status, muscle weakness, lack of coordination, difficulty in walking, dysphasia oropharyngeal phase, diabetes without complications type 2, essential hypertension, atrial fibrillation, polyneuropathy in diabetes and esophageal reflux.</p> <p>On 1/11/2016 at 10:00 A.M. an investigation report was reviewed. The report indicated that on 1/8/2016</p>	F 0225	F0225 There were no further incidence or complaints from resident 211. Resident 211 has voiced satisfaction with care. Resident Council minutes were reviewed for complaints of issues related to care. CNA 6 was suspended during investigation of the incident per facility policy and was reported to ISDH. CNA involved was suspended, counseled, and reinstated. CNA was referred to employee assistance program and completed additional in-services related to abuse and communication. Facility uses ABQIS program and 24 hour report sheet to monitor resident satisfaction. Concerns or issues identified are reported to the Administrator immediately and investigated for further action. The Abuse Investigation policy was reviewed(Attachment A). All staff members were in serviced and re educated on abuse reporting policy to notify the immediate supervisor of any	02/01/2016			

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	<p>Resident #211 alleged CNA #6 (Certified Nursing Assistant) forced him to used a mechanical lift and told him if he did not stop screaming he would have to leave. The record further alleged that she put her hand on his mouth and told him to be quiet. The incident occurred on 1/7/2016 at 2:01 P.M.</p> <p>During an interview on 01/12/2016 at 2:44 P.M., CNA #7 indicated that she was assisting CNA #6 in transferring Resident #211 to his recliner. Resident #211 began "screaming." CNA #7 indicated that CNA #6 covered Resident #211's mouth and indicated that if he did not stop screaming he would have no where else to go. CNA #7 indicted that CNA #6 began hitting Resident #211 on the chest and telling him to "stop." CNA #7 indicated she than went to lunch and later went home. She further indicated that she did not report to anyone regarding the event until after she went home for the day.</p> <p>On 01/04/2016 at 11:00 A.M., the Administrator provided a policy titled, " Abuse - Investigation of Abuse and Protection of the Resident," dated 08/2015, and indicate that policy was the one currently used by the facility. The policy indicated "...2. Staff incidents that allege abuse, neglect, involuntary</p>		<p>complaints. The supervisor will immediately notify the Administrator or designee if the Administrator is not available. Nursing staff will communicate any alleged abuse/complaints to their Nurse Team Leader or designee immediately. The NTL or designee will be responsible to notify the Administrator or designee immediately. On weekend and holidays all staff will report to the nurse on call, who will in turn immediately notify the Administrator and DON. The DON or designee will review/audit the 24 hour report sheets daily for complaints from residents. The Administrator or designee will initiate appropriate reporting, investigation, and interventions from protection of harm. These interventions will be communicated with the physician, family, and staff. This is an on going basis. The DON or designee will report findings to QAPI committee at least monthly for review, recommendations, and tracking. Alleged date of compliance 2/1/2016</p>	

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F 0226 SS=D Bldg. 00	<p>seclusion and/or misappropriation of resident property, will be investigated as follows: a. The Administrator must be notified immediately...."</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to implement the facility policy for reporting an allegation of abuse to the Administrator for 1 of 4 allegations of abuse reviewed.</p> <p>Finding includes: On 01/08/2016 at 11:33 A.M., a review of the clinical record for Resident #211 was conducted. Resident #211 was admitted on 04/07/2015. The resident's diagnoses included, but were not limited to, altered mental status, muscle weakness, lack of coordination, difficulty in walking, dysphasia oropharyngeal</p>	F 0226	F0226 There were no further incidence or complaints from resident 211. Resident 211 has voiced satisfaction with care. Resident Council minutes were reviewed for complaints of issues related to care. CNA 6 was suspended during investigation of the incident per facility policy and was reported to ISDH. CNA involved was suspended, counseled, and reinstated. CNA was referred to employee assistance program and completed additional in-services related to abuse and communication. Facility uses ABQIS program and 24 hour report sheet to monitor resident satisfaction. Concerns or issues	02/01/2016

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	<p>phase, diabetes without complications type 2, essential hypertension, atrial fibrillation, polyneuropathy in diabetes, and esophageal reflux.</p> <p>On 1/11/2015 at 10:00 A.M., a review of an allegation of abuse was conducted. The allegation indicated that on 1/8/2016 Resident #211 alleged CNA #6 (Certified Nursing Assistant) forced him to used a mechanical lift and told him if he did not stop screaming he would have to leave. The record further alleged that she put her hand on his mouth and told him to be quiet. The incident occurred on 1/7/2016 at 2:01 PM.</p> <p>During an interview on 01/12/2016 at 2:44 P.M., CNA #7 indicated that she was assisting CNA #6 in transferring Resident #211 to his recliner. Resident #211 began "screaming." CNA #7 indicated that CNA #6 covered Resident #211's mouth and indicated that if he did not stop screaming he would have no where else to go. CNA #7 indicted that CNA #6 began hitting Resident #211 on the chest and telling him to "stop." CNA #7 indicated she than went to lunch and later went home. She further indicated that she did not report to anyone regarding the event until after she went home for the day.</p>		<p>identified are reported to the Administrator immediately and investigated for further action. The Abuse Investigation policy was reviewed(Attachment A). All staff members were in serviced and re educated on abuse reporting policy to notify the immediate supervisor of any complaints. The supervisor will immediately notify the Administrator or designee if the Administrator is not available. Nursing staff will communicate any alleged abuse/complaints to their Nurse Team Leader or designee immediately. The NTL or designee will be responsible to notify the Administrator or designee immediately. On weekend and holidays all staff will report to the nurse on call, who will in turn immediately notify the Administrator and DON. The DON or designee will review/audit the 24 hour report sheets daily for complaints from residents. The Administrator or designee will initiate appropriate reporting, investigation, and interventions from protection of harm. These interventions will be communicated with the physician, family, and staff. This is an on going basis. The DON or designee will report findings to QAPI committee at least monthly for review, recommendations, and tracking. Alleged date of compliance 2/1/2016</p>		

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F 0241 SS=D Bldg. 00	<p>On 01/04/2016 at 11:00 A.M., the Administrator provided a policy titled, " Abuse - Investigation of Abuse and Protection of the Resident," dated 08/2015, and indicate that policy was the one currently used by the facility. The policy indicated "...2. Staff incidents that allege abuse, neglect, involuntary seclusion and/or misappropriation of resident property, will be investigated as follows: a. The Administrator must be notified immediately...."</p> <p>3.1-28(a)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on record review and interview, the facility failed to ensure 1 of 18 residents interviewed were treated by nursing staff with respect and their dignity maintained. (Resident #258)</p> <p>Findings include:</p>	F 0241	241 There were no further complaints from resident 258. Resident 258 did not suffer from any psychosocial distress. Resident Council minutes were reviewed for complaints of issues related to dignity and respect. Facility uses ABQIS program and 24 hour report sheet to monitor resident satisfaction. Concerns or	02/01/2016	

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	<p>An interview was conducted on 01/07/2016 at 1:55 P.M. with alert and oriented Resident #258. Resident #258 indicated one staff member had not treated her with respect and dignity. She indicated on 12/25/15 at 4:30 A.M., she had received assistance from CNA (Certified Nursing Assistant) #31 to utilized a bed pan. After she had finished with the bedpan, Resident #250 asked CNA #31 to transfer her to the recliner chair beside the bed because she was having trouble sleeping in the bed and thought perhaps she would be more comfortable in the recliner chair. CNA #31 declined her request and stated to Resident # 258, "Well, you'll have to wait your turn like everyone else." Resident #258 indicated she was not gotten up for the day until almost 9:00 A.M. and was late for breakfast. She indicated she though CNA #31 was mad because she had to work on Christmas. She indicated CNA #31 had taken care of her since and had "sweetened" up.</p> <p>The clinical record for Resident #258 was reviewed on 01/07/2016 at 1:55 P.M. Resident #258 was admitted to the facility on 12/22/15, with diagnoses, including but not limited to: displaced communited fracture of the femur, thrombocytopenia, hypothyroidism, acute anemia, bipolar disorder,</p>		<p>issues identified are reported to the Administrator immediately and investigated for further action. Nursing staff were in serviced and re educated on dignity and respect, reminding staff that dignity and respect must be maintained whenever the resident needs are being met (Attachment B). Nurse Team Leader or designee will monitor for dignity issues daily during rounds and via the 24 hour report book. Issues will be corrected as needed and interventions communicated with staff. Abnormal findings will be reported to the DON or designee on Health care report sheets(Attachment C). This is an ongoing. The DON,designee will report findings to QAPI committee at least monthly for review, recommendations, and tracking. Alleged date of compliance 2/1/2016</p>				

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	<p>hypertension, history of falling, muscle weakness and difficulty walking.</p> <p>A nurse's note from admission to 01/01/16, did not indicate any note regarding an incident with a staff member upsetting her or not getting her out of bed.</p> <p>On care plan meeting note, dated 01/06/16, Social Worker #32 indicated the family was satisfied with the care and had voiced no issues.</p> <p>During an interview, on 01/11/2016 at 10:44 A.M., LPN (Licensed Practical Nurse) #33 indicated the resident had complained about not getting a B12 (vitamin) injection and about her roommate's loud television but no specific care issues.</p> <p>During an interview, on 01/11/16 at 11:45 A.M., Resident #258 indicated she had notified staff of her concern with CNA #31 during a care conference meeting.</p> <p>During an interview, on 01/11/2016 at 2:46 P.M., Social Worker #32 indicated Resident #258 did not document the concern with CNA #31 and Resident #258 because it was a one time occurrence. She further indicated she did</p>			

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	<p>not do any follow up to the concern voiced by Resident #258. She indicated the nurse manager, LPN #33 was also aware of the issue. Social Service #32 indicated Resident #258 had stated on Christmas day a nursing staff member was "grouchy" and she asked to get up at 4:30 A.M. and at 6:00 A.M. and she did not get her up out of bed as she requested. Per the description by the resident during the care conference, the Social Service Director indicated she did not consider it an allegation (of abuse) just a complaint about an "attitude" of the staff member. Social Service #32 indicated she discussed the issue with LPN #32 and did not remember reporting the issue to the Administrator.</p> <p>During an interview, on 01/11/2016 at 2:58 P.M., LPN #33, indicated she did recall on Christmas day, Resident #258 did complain about the issues. She indicated Resident #258 stated she turned on her light on at 6:00 A.M. and wanted to get up and the CNA told her she would have to wait a few minutes. She indicated the resident told her she thought CNA #31 "doesn't want to be here today" and when she asked why, Resident #258 indicated "she (CNA #31) was grumpy and told me I would have to wait (to get up)." LPN #33 did not remember anything else about the complaint. LPN</p>			

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F 0246 SS=D Bldg. 00	<p>#33 indicated she offered to change the work assignment for CNA #31 but Resident #258 indicated she did not need to change her work assignment. LPN #33 indicated she spoke with Resident #258 a couple of time later that day and she was upset but she was upset about a telephone issue. LPN #33 indicated she did not report the issue to the Administrator or document the concern as the resident did not have concerns with receiving future care from CNA #31.</p> <p>During an interview, on 01/12/2016 at 10:59 A.M.,the Administrator indicated she did not recall being notified of a concern around Christmas involving a staff member and Resident #258.</p> <p>3.1-3(t)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on record review and interviews, the facility failed to ensure 2 of 18</p>	F 0246	246 Resident 18 and 258, routine bathing schedule is maintained. Resident 18 or 258 had no further	02/01/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/12/2016	
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527			
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	<p>residents interviewed were offered routine bathing opportunities in a timely fashion. (Resident #18 and #258)</p> <p>Findings include:</p> <p>1. During an interview, on 01/05/2016 at 11:05 A.M., alert and oriented Resident #18 indicated she had received a whirlpool bath once and had been given only one shower while at therapy in the bathroom with a bench. She indicated she had not had a bath or shower since. The resident indicated on 01/05/16, she had been offered a shower but she had declined because she had already gotten up and was dressed. She further indicated on 01/05/16, she told staff she would prefer to receive a shower in the evening not in the morning.</p> <p>A record review for Resident #18 was conducted on 1/12/2016 at 3:50 P.M. Resident #18 was admitted to the facility, on 12/05/15, with diagnoses, including but not limited to: right hip pain, hematoma right buttocks, spinal stenosis, sick sinus syndrome, osteoporosis, hypertension, hypercholestrolemia, history of bilateral hip and knee replacements and pace maker.</p> <p>There were no nursing notes indicating the resident had been refusing bathing</p>		<p>complaints or concerns. All resident routine bathing schedule have been reviewed and revised to meet their needs. Nursing staff have been in serviced and re educated on resident care policy on bathing needs(Attachment B). Nursing staff were reminded to chart if residents refuse bathing opportunities or uncooperative in the POC charting system. Facility will use ABQIS tool to monitor resident satisfaction with their bathing schedules, and correct any concerns or issues. Nurse Team Leader will audit and monitor bathing schedules twice weekly via "point of care" charting system to make sure residents receive their bath/shower. The results of this audit will be reported to the DON or designee via the community healthcare report sheet(Attachment C). DON or designee will submit findings at least monthly to QAPI for review, recommendations and tracking. Alleged date of 2/1/2016</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/12/2016
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NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527
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	<p>opportunities or uncooperative with care.</p> <p>The initial (MDS) Minimum Data Set admission assessment, completed on 12/15/15, indicated the resident scored a 15/15 on the BIMS (Brief Interview for Mental Status) which indicated she was cognitively intact. The assessment indicated it was very important for her to choose between a tub bath, shower or bed bath, and she required physical assistance for bathing needs.</p> <p>The CNA (Certified Nursing Assistant) assignment sheets for the nursing unit indicated Resident #18 was scheduled to receive a shower on Tuesday and Friday's during the day. The resident should have received a shower on December 8, 11, 15, 18, 22, 25, and 29, and January 1 and 5th.</p> <p>The bathing/shower records for Resident #18 indicated she had been documented as having received a whirlpool bath on 12/12/15 in the evening, a shower on 12/14/15 and 12/21/15. She received a whirlpool on 12/23/15 in the evening. She did not receive any further bathing until 01/02/15 in the evening, when she was documented as having received a whirlpool bath.</p> <p>During an interview, on 01/07/16 at 2:20</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/12/2016
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	<p>P.M., LPN (Licensed Practical Nurse) #33 indicated she did not know why Resident #18 had not received any bathing opportunities for the first whole week of her admission and had gaps over a week long at the end of December where she was not given any bathing opportunities. LPN #33 did not know what days Resident #18 was scheduled to receive bathing opportunities. She also was not aware Resident #18 preferred to receive bathing in the evening hours.</p> <p>2. During an interview, conducted on 1/6/16 at 10:22 A.M., Resident #258 indicated she had staples on her leg and had not yet been offered a shower or bed bath. She also indicated her hair had not been washed and it was itching and bothering her.</p> <p>The clinical record for Resident #250 was reviewed on 01/07/2016 1:55:59 PM. Resident #250 was admitted to the facility on 12/22/15, with diagnoses, including but not limited to: displaced commuted fracture of the femur, thrombocytopenia, hypothyroidism, acute anemia, bipolar disorder, hypertension, history of falling, muscle weakness and difficulty walking.</p> <p>The initial MDS assessment, completed on 12/29/15, indicated the resident scored</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/12/2016	
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527			
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	<p>a 15/15 on the BIMS, indicated she was cognitively intact. The assessment also indicated it was very important for her to choose between a tub bath, shower, bed bath or sponge bath.</p> <p>During an interview, on 01/07/2016 at 2:22 P.M., LPN #33 indicated the resident would not have had a shower due to her staples but would have had a "sponge bath." When asked for copies of the documentation, LPN #33 indicated Resident #258 was only scheduled to receive bathing once a week on Mondays. She indicated the documentation was mostly blank for those days.</p> <p>The bathing documentation for Resident #258 indicated on 12/28/15 the documentation was blank and left incomplete. On 01/04/16, a second shift CNA had documented the resident had refused.</p> <p>A CNA assignment sheet for Resident #258 indicated she was supposed to receive bathing opportunities on Wednesdays and Saturdays in the evenings. The resident should have received a bathing opportunity on December 23, 26, 30, 2015 and January 2 and 6, 2016.</p>						

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NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527
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	<p>During an interview, on 01/07/16 at 3:00 P.M., LPN #33 indicated she had no further information and did not know why a bed bath was not provided on a routine basis for Resident #258. LPN #33 indicated she would make sure Resident #258 was assisted with a bed bath and had her hair washed.</p> <p>During an interview, on 01/08/16 at 2:00 P.M., Resident #258 she indicated she had gotten her staples out at the doctor's office earlier in the day and could finally have a shower and wash her hair. She indicated no one had offered to bath or wash her hair last evening.</p> <p>A current policy and procedure titled, "Nursing Services - Resident Care, revised on 02/13, was provided by LPN #33 on 1/12/16 at 2:30 P.M. The policy and procedure indicated the following: "...3. Each resident shall be offered a complete bath at least twice a week, and hair shall be shampooed at least once a week, unless the resident chooses otherwise...."</p> <p>3.1-3(v)(1)</p>			

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NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527		
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F 0280 SS=D Bldg. 00	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, record review and interviews, the facility failed to ensure an activity care plan was updated to reflect the resident's current needs for 1 of 3 residents reviewed for activity participation. (Resident #103)</p> <p>Finding includes:</p> <p>During the mid morning hours through mid afternoon hours on 01/05/16 and 01/06/16, Resident #103 was not observed to participate in any out of room activities.</p>	F 0280	280 Resident 103, activity care plan as been reviewed and revised to meet her present needs. All residents' care plans have been reviewed by activities and nursing staff to make sure activity needs are appropriate and met per individualized care plan. Staff will document resident activities via the "point of care" charting system. Activities and nursing staff were in serviced and re educated on accommodating residents needs while in their rooms and encourage all residents to participate in the activity of their choice(Attachment D). The Life Enhancement	02/01/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/12/2016
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NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527
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	<p>Resident #103 was observed on 01/08/15 from 8:40 A.M. - 11:27 A.M., lying in her bed asleep. At 11:27 A.M., she received visitors who woke her up and she received nursing care and her lunch meal tray was delivered to her.</p> <p>On 01/08/15 from 1:50 P.M. - 3:00 P.M., Resident #103 was observed seated in her recliner in her room with the curtain pulled around her. She did not receive any activities.</p> <p>Resident #103 was observed, on 01/11/16 from 8:30 A.M. - 10:00 A.M., lying in her bed asleep. At 10:00 A.M., she received nursing care and was transferred into her recliner. At 10:33 A.M.- 10:48 A.M., a volunteer was in her room reading the Bible to her. At 11:40 A.M., her lunch tray was delivered to her. She was observed feeding herself mashed potatoes at 11:45 A.M. She was observed asleep with a bowl of dessert in her lap at 12:30 P.M.</p> <p>The clinical record for Resident #103 was reviewed on 01/11/2016 10:46 A.M. Resident #103 was admitted to the facility on 01/29/12, with diagnoses, including but not limited to: hypertension, esophageal reflux, depressive disorder, asthma, heart disease, diabetes, constipation, paralytic</p>		<p>Coordinator or designee will monitor the implementation of activity interventions weekly using the activity chart via the "point of care" charting system. Quarterly activity care plans are audited and reviewed and revised as needed by the Life Enhancement Coordinator or designee and reported to the Social Service Director. The SSD or designee will submit a summary of findings to QAPI chairperson monthly for review, recommendations and tracking. Alleged date of compliance 2/1/2016</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/12/2016
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NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527
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	<p>ileus, history of DVT (deep vein thrombosis), anxiety, chronic kidney disease, dementia with behavior disturbances and arteriosclerosis.</p> <p>The quarterly MDS (Minimum Data Set) assessment, completed on 11/06/15, indicated the resident had short and long term memory impairment and was moderately cognitively impaired. Resident #103 required extensive staff assistance for transfers and wheelchair locomotion.</p> <p>The Activity assessment, completed on 11/02/15, indicated the resident preferred to be in her room, have a "reader 2 times a week," and enjoyed watching birds out of her room. The assessment indicated she fell asleep if she tried to read to herself and listening to music in her room "drove her nuts" but she liked music on the unit.</p> <p>The care plan regarding activities, current through 11/20/15, indicated she was only slightly interested in group activity and wanted to be able to decline when she felt like it. The approach was to provide encouragement towards activities available and reminders.</p> <p>There was no care plan intervention to address the resident's current preference</p>			

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NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527
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F 0282 SS=D Bldg. 00	<p>to stay in her room, receive 1:1 activities and watch the birds, to ensure she received some sort of activity on a routine basis.</p> <p>The activity participation log, from 01/04/16 - 01/11/16, indicated the resident had received 2 social activities, including a 1:1 visit on 01/07/16, a 30 minute social activity on 01/08/16 and a social activity 1:1 visit for 5 minutes on 01/11/16. The 01/08/16, visit was not observed to have occurred. There were days when no activity of any kind had occurred for Resident #103.</p> <p>During an interview, on 01/12/16 at 9:30 A.M., LPN (Licensed Practical Nurse) #33 indicated Resident #103 was very receptive to visits in her room and enjoyed conversations, liked to talk about birds and watch birds, and liked the pet visits. She indicated the resident at some point had declined books or music on tape, but really enjoyed being read to by the volunteer.</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/12/2016
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NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527
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	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interviews, the facility failed to ensure toileting was provided as care planned for 3 of 4 residents reviewed for incontinence. (Resident #3, 103 and 172)</p> <p>Findings include:</p> <p>1. Resident #3 was observed, on 01/06/16 from 9:30 A.M. - 12:05 P.M., to not have received any toileting opportunity. At 12:05 P.M., a CNA (Certified Nursing Assistant) brought in her lunch tray and started feeding her. She was observed to remain seated in her recliner in her room for extended periods of time.</p> <p>Resident #3 was observed, on 01/08/16 from 8:40 A.M. - 12:01 P.M., and was not offered toileting. At 12:01 P.M., a CNA entered her room and sat down to feed her lunch.</p> <p>On 01/11/16 from 8:30 A.M. - 12:30 P.M., Resident #3 was observed seated in her room in her recliner. She was not offered any toileting opportunity. She was fed her lunch by CNA #35 at 11:45 A.M. but was not offered any toileting or incontinence care.</p>	F 0282	<p>282 Resident 103 and 172 toileting schedule were followed per individual care plan. Both residents were encouraged to follow schedule toileting patterns. Deviations from the toileting schedule will be documented in POC All residents care plans were audited, reviewed and revised as needed to meet their individualized toileting schedule/pattern. All nursing staff was in serviced and re educated to follow individualized toileting care plans/ patterns (Attachment E). A coding system was developed to communicate toileting plans with staff. Staff was educated on the coding system(Attachment F) . Staff will encourage resident to follow toileting patterns per their individual care plan, and chart using the POC charting system results and deviations from the plan. TL or designee will audit toileting patterns weekly using the "point of care" charting system to make sure individualized toileting program is being followed. Abnormal finding will be reported using the Healthcare report sheet to the DON or designee (Attachment C). DON or designee will submit findings at least monthly to QAPI for review, recommendations, and tracking. Alleged date of compliance</p>	02/01/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/12/2016
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NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527
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	<p>The clinical record for Resident #3 was reviewed on 01/08/2016 at 9:48 A.M. Resident #3 diagnoses included, but were not limited to, history of cerebral vascular accident, hypertension, spastic hemiplegia, diabetes, hypothyroidism, iron deficiency anemia, hearing loss, insomnia, blindness both eyes, contracture of joint, chronic kidney disease, depressive disorder and peripheral vascular disease.</p> <p>The care plan related to continence, initiated on 01/30/14 and current through 03/03/16, indicated the goal was for the resident to have two less incontinent episodes . The interventions was for staff to anticipate and offer toileting upon rising in the am, after breakfast, before and after lunch and supper, at bedtime and prn (as needed), staff to provide extensive staff assistance with transfers and clothing management. Staff assist with pericare and clothing management. Staff to ensure fresh water at bedside daily. Staff to watch for changes. Staff to offer bedpan at night.</p> <p>During an interview, 01/12/2016 at 10:09 A.M., CNA #34 indicated the resident "yells" at them for toileting assistance but otherwise they help her to the bathroom with a stand up lift, first thing in the morning, before lunch and then after</p>		2/1/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/12/2016
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NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527
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	<p>lunch before second shift starts. He indicated the toileting was charted in the computer.</p> <p>2. Resident #172 was observed, on 01/06/16 from 9:30 A.M. - 12:05 P.M., seated in her wheelchair by a table across from the nurses station. She was not observed to be toileted.</p> <p>Resident #172 was observed on 01/08/16 from 8:40 A.M. - 12:01 P.M. She was seated in her wheelchair at a table across from the nurse's station from 8:40 A.M. - 9:26 A.M. At 9:26 A.M., she was taken off of the unit to an activity and remained at the activity until 11:11 A.M. when she was pushed back to the unit by activity staff. Activity staff were directed to push Resident #172 back up to the table across from the nurse's station. She was not toileted. She remained in her wheelchair at the table from 11:11 A.M. through 12:01 P.M. At 12:01 P.M., she was observed feeding herself lunch.</p> <p>Resident #172 was observed on 01/11/16 from 8:30 A.M. through 12:35 P.M., seated in her wheelchair at a table across from the nurse's station. She was awake and listened actively to an activity on the unit, but was never offered any toileting.</p> <p>The clinical record for Resident #172 was</p>			

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NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527
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	<p>reviewed on 01/11/2016 9:26 A.M. Resident #172's diagnoses, included but not limited to: Alzheimer's disease, osteoarthritis, glaucoma, hypothyroidism, urinary incontinence, anxiety, edema, lack of coordination, paralysis agitans, muscle weakness and abnormal posture.</p> <p>The Incontinence care plan, current through 01/29/16, indicated staff were to anticipate her needs and offer toileting upon rising in the am, after breakfast, before and after lunch and supper at bedtime and prn (as needed).</p> <p>During an interview on 01/12/2016 at 10:13 A.M., CNA #36 indicated Resident #172 required extensive assistance and was toileted routinely first thing in the morning and after lunch. Resident #172 was also checked for incontinence sometimes in between.</p> <p>3. Resident #103 was observed, on 01/08/16 from 8:40 A.M. - 11:27 A.M., lying in her bed asleep. No staff were observed to provide any care for Resident #103. At 11:27 A.M., she received visitors who woke her up and she requested to go to the bathroom. She was provided a bedpan and was able to urinate but had also been incontinent of urine.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/12/2016
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NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527
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	<p>Resident #103 was observed on 01/11/16 from 8:30 A.M. - 10:00 A.M. lying in her bed asleep. At 10:00 A.M., CNA #35 provided incontinence care for Resident #103 and changed her brief. She was not offered a bedpan or toileted. She was offered to be dressed in street clothes but the resident declined. She was transferred to her recliner at 10:00 A.M. She remained in her recliner from 10:00 A.M. - 12:35 P.M. She was provided oral care, beverages and her lunch tray, but she was not toileted.</p> <p>The clinical record for Resident #103 was reviewed on 01/11/2016 10:46 A.M. Resident #103's diagnoses, included but not limited to: hypertension, esophageal reflux, hypercholesterolemia, depressive disorder, asthma, heart disease, diabetes, constipation, paralytic ileus, anxiety, chronic kidney disease, dementia with behavior disturbances and arterioscleroses.</p> <p>The care plan related to urinary incontinence, current through 02/05/16, indicated the resident had a restorative urinary toileting care plan and was to be offered toileting ac (before meals), pc (after meals), hs (hour of sleep), and prn (as needed). She was to be provided pull ups (incontinent briefs) and watch for</p>			

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	<p>incontinence every 2 hours.</p> <p>During an interview, on 01/12/2016 at 10:52 A.M., CNA #37 indicated the resident was usually incontinent of bladder, used a bedpan on request occasionally, and was to be checked and changed every couple hours. When asked about the Restorative Toileting Plan, CNA #37 did not seem aware of the plan.</p> <p>Review of the January 2016 restorative documentation for Resident #103 indicated "no" was written on the documentation on 10 of 11 days of documentation. Some of the documentation for the time frames required by the care plan were left blank on all 11 of 11 days. On 01/04/16, "no" was documented at 12:00 A.M. and 4:00 A.M., and there was no further documentation for the day. On 01/08/16, there was only one incontinent episode documented at 5:00 A.M. In addition, it was unclear when "voided" and "incontinent" was documented if the resident had also been provided toileting with either a bed pan or the toilet.</p> <p>3.1-35(g)(2)</p>			

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F 0311 SS=D Bldg. 00	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS</p> <p>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on observation, interview and record review, the facility failed to ensure 1 of 3 residents reviewed for Activities of Daily Living (ADL) assistance were provided the needed assistance for daily dressing and oral care. (Resident #34)</p> <p>Finding includes:</p> <p>On 01/08/2016 at 12:02 P.M., a review of the clinical record for Resident #34 was conducted. The resident's diagnoses included, but were not limited to: dementia with behavioral disturbance, atrial fibrillation, hypertension, sinatrial node dysfunction, cardiac murmurs, cardiac pacemaker and depressive disorder.</p> <p>A care plan for Resident #34 indicated "...I am not aware when my clothes are soiled and will put the same outfit on day after day if staff did not offer assist daily. Staff offer limited to extensive assist with ADL's (activities of daily living)...."</p>	F 0311	<p>311 Resident 34 can be uncooperative and refuse care from staff. Staff will attempt to assist resident 34 with oral care and dressing in the morning. Multiple attempts to assist resident 34 will be made if necessary; refusal of care will be documented in POC. On 1/21/2016 a family conference was initiated to meet with care givers on how to help resident with ADLs in a timely and acceptable manner. Family had showed interest in assisting staff with approaches during shower/bath times. Resident's e-care plan was reviewed and revised to meet resident's need appropriately in a timely manner. All resident care plans were reviewed to attempt to meet resident needs. Nursing staff were in serviced and re educated (Attachment G) on approaches to provide care for residents with behavioral disturbances, to seek for assistance when resident resist ADLs and chart if any resistance to care occurred from resident and approaches</p>	02/01/2016

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	<p>A form titled "Daily Charting for Saturday, January 02/2016," indicated under category of "...Guidance - How resident maintains personal hygiene; including combing hair, brushing teeth, shaving, apply makeup, washing and drying face, hands, and perineum..." that "...Activity Did Not Occur - activity (or any part of the ADL) was not performed by resident or staff at all over the entire 7 -day period..." The form indicated the same information was categorized for day shift and night shift.</p> <p>On 01/12/2016 at 11:02 A.M., Resident #34 was observed to be dressed in the same clothes she was wearing on 1/11/2016. The sweater she was wearing had a white substance soiling more than half of the front of it. The white substance was also observed around the cuffs of her sleeves.</p> <p>During an interview, on 01/11/2016 at 3:00 P.M., RN (Registered Nurse) #9 indicated she had worked several days last week and she did not have any staff report refusal of resident's care to her. She further indicated that staff are "good about" reporting to her anytime a resident refused care.</p> <p>During an interview, on 1/12/2016 at</p>				<p>attempted, in POC charting. Nurse Team Leader or designee will audit documentation on ADLs in POC weekly. These audits will review approaches to care, refusal, and completion of ADLs. The printed report will be given to the DON or designee for compliance and follow up. Any arising problems will be addressed immediately, with interventions communicated with staff. DON or designee will submit findings at least monthly to QAPI for review, recommendations and tracking. Alleged date of compliance 2/1/2016</p>		

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NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527			
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F 0315 SS=D Bldg. 00	<p>3:18 P.M., Unit Manager #9 indicated Resident #34 had not received oral care or dressing assistance twice a day for 7 of 7 days reviewed.</p> <p>3.1-38(a)(2)(A)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review and interviews, the facility failed to ensure toileting was provided as care planned to restore as much normal bladder function as possible for 3 of 4 residents reviewed for incontinence. (Resident #3, 103, and 172)</p> <p>Findings include:</p> <p>1. Resident #3 was observed on 01/06/16 from 9:30 A.M. - 12:05 P.M. not to have</p>	F 0315	<p>315 Toileting Plans for residents 3, 103, 172 have been reviewed. A coding system was developed to communicate toileting plans with staff. Staff was educated on the coding system. All toileting plans of resident have been reviewed. A coding system was developed to communicate toileting plans with staff. Staff were educated on the coding system (Attachment F). Nursing staff shall document in POC the resident bladder functions of the shift. At time of admission and</p>	02/01/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/12/2016
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	<p>received any toileting opportunity. At 12:05 P.M., a CNA (Certified Nursing Assistant) brought in her lunch tray and started feeding her. She was observed to remain seated in her recliner in her room for extended periods of time.</p> <p>Resident #3 was observed on 01/08/16 from 8:40 A.M. - 12:01 P.M. and was not offered toileting. At 12:01 P.M., a CNA entered her room and sat down to feed her lunch.</p> <p>On 01/11/16 from 8:30 A.M. - 12:30 P.M., Resident #3 was observed seated in her room in her recliner. She was not offered any toileting opportunity. She was fed her lunch by CNA #35 at 11:45 A.M. but was not offered any toileting or incontinence care.</p> <p>The clinical record for Resident #3 was reviewed on 01/08/2016 at 9:48 A.M. Resident #3 was admitted to the facility on 09/11/97 with diagnoses, including but not limited to: history of cerebral vascular accident, hypertension, spastic hemiplegia, diabetes, hypothyroidism, hyperlipidemia, iron deficiency anemia, hearing loss, insomnia, blindness both eyes, contracture of joint, chronic kidney disease, depressive disorder and peripheral vascular disease.</p>		<p>change in continence pattern, a 3 day bladder diary will be completed and a B&B assessment will be completed. This shall be done before developing a restorative toileting plan. Individualized interventions will be communicated to staff. Residents with a restorative toileting plan will be flagged in POC with an additional charting icon. Nursing staff were in serviced and re educated on Bowel & Bladder program and the coding system (Attachment E & H). TL or designee will monitor charting weekly via POC charting system to make sure toileting completed per care plan to restore bladder function. A printed report of charting will be reported to DON or designee for compliance and follow up. DON or designee will submit summary of findings at least monthly to QAPI committee for review, recommendations and tracking. Alleged date of compliance 2/1/2016</p>	

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	<p>An annual Minimum Data Set (MDS) assessment, completed on 11/19/15, indicated the resident required extensive staff assistance for bed mobility, and transfers and was totally dependent for wheelchair locomotion on the unit. In addition, the resident required extensive staff assistance from two staff for toileting and personal hygiene needs and was frequently incontinent of her bowels and bladder and was not on any toileting program.</p> <p>The Bowel and Bladder assessment, completed on 11/24/15, indicated the resident demonstrated functional incontinence, frequency, nocturia and urgency. The resident required two staff assistance to transfer to the toilet, was aware of her needs but confused, and was to be toileted routinely before/after meals, at bedtime and check and change every 2 hours.</p> <p>The care plan related to continence, initiated on 01/30/14, indicated the goal was for the resident to have two less incontinent episodes . The interventions were: staff to anticipate/offer toileting upon rising in the am, after breakfast, before and after lunch and supper, at bedtime, as needed, staff to provide extensive staff assistance with transfers and clothing management. Staff assist</p>			

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	<p>with pericare and clothing management and staff to offer bedpan at night.</p> <p>During an interview, on 01/12/2016 at 10:09 A.M., CNA #34 indicated the resident "yells" at them for toileting assistance but otherwise they help her to the bathroom with a stand up lift, first thing in the morning, before lunch and then after lunch before second shift starts. He indicated the toileting was charted in the computer.</p> <p>2. Resident #172 was observed 01/06/16 from 9:30 A.M. - 12:05 P.M. seated in her wheelchair by a table across from the nurses station. She was not observed to be toileted.</p> <p>Resident #172 was observed on 01/08/16 from 8:40 A.M. - 12:01 P.M. She was seated in her wheelchair at a table across from the nurse's station from 8:40 A.M. - 9:26 A.M. At 9:26 A.M., she was taken off of the unit to an activity and remained at the activity until 11:11 A.M. when she was pushed back to the unit by activity staff. Activity staff were directed to push Resident #172 back up to the table across from the nurse's station. She was not toileted. She remained in her wheelchair at the table from 11:11 A.M. through 12:01 P.M. At 12:01 P.M. she was observed feeding herself lunch.</p>			

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	<p>Resident #172 was observed on 01/11/16 from 8:30 A.M. through 12:35 P.M., seated in her wheelchair at a table across from the nurse's station. She was awake and listened actively to an activity on the unit, but was never offered any toileting.</p> <p>The clinical record for Resident #172 was reviewed on 01/11/2016 9:26 A.M. Resident #172 was admitted to the facility on 03/27/13 with diagnoses, including but not limited to: Alzheimer's disease, osteoarthritis, glaucoma, hypothyroidism, urinary incontinence, anxiety, edema, lack of coordination, paralysis agitans, muscle weakness and abnormal posture.</p> <p>The quarterly MDS assessment, completed on 10/22/15, indicated the resident scored a 6 of 15 on Brief Interview Mental Status (BIMS) and was severely cognitively impaired, required extensive staff assistance for transfer, wheelchair locomotion, dressing, personal hygiene and toileting needs. Resident #172 was always continent of her bowels and always incontinent of her bladder.</p> <p>A bowel and bladder assessment, completed on 10/22/15, indicated the resident exhibited dribbling, functional</p>			

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	<p>incontinence, nocturia and urine precipitated by cough/sneeze, was confused, transferred to the toilet with two staff, needed assistance to manage clothing, was to be toileted before/after meals, at bedtime and as needed.</p> <p>The care plan related to Incontinence, current through 01/29/16, indicated staff were to anticipate her needs and offer toileting upon rising in the am, after breakfast, before and after lunch and supper at bedtime and prn (as needed).</p> <p>During an interview, on 01/12/2016 10:13:42 A.M., CNA #36 indicated Resident #172 required extensive assistance and was toileted routinely first thing in the morning and after lunch. Resident #172 was also checked for incontinence sometimes in between.</p> <p>3. Resident #103 was observed on 01/08/16 from 8:40 A.M. - 11:27 A.M. lying in her bed asleep. No staff were observed to provide any care for Resident #103. At 11:27 A.M., she received visitors who woke her up and she requested to go to the bathroom. She was provided a bedpan and was able to urinate but had also been incontinent of urine.</p> <p>Resident #103 was observed, on 01/11/16</p>			

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	<p>from 8:30 A.M. - 10:00 A.M., lying in her bed asleep. At 10:00 A.M., CNA #35 provided incontinence care for Resident #103 and changed her brief. She was not offered a bedpan or toileted. She was offered to be dressed in street clothes but the resident declined. She was transferred to her recliner at 10:00 A.M. She remained in her recliner from 10:00 A.M. - 12:35 P.M. She was provided oral care, beverages and her lunch tray, but she was not toileted.</p> <p>The clinical record for Resident #103 was reviewed on 01/11/2016 10:46 A.M. Resident #103 was admitted to the facility on 01/29/12, with diagnoses, including but not limited to: hypertension, esophageal reflux, hypercholesterolemia, depressive disorder, asthma, heart disease, diabetes, constipation, paralytic ileus, anxiety, chronic kidney disease, dementia with behavior disturbances and arterioscleroses.</p> <p>The most recent quarterly MDS assessment, completed on 11/06/15, indicated the resident had short and long term memory impairment and was moderately cognitively impaired, required extensive staff assistance for bed mobility, transfers, wheelchair locomotion, dressing, toilet use, personal</p>			

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	<p>hygiene and bathing. The resident required limited staff assistance for eating, was continent of bowel and frequently incontinent of her bladder.</p> <p>The care plan related to urinary incontinence, current through 02/05/16, indicated the resident had a restorative urinary toileting care plan and was to be offered toileting before and after meals, at bedtime and as needed. She was to be provided pull ups and observed for incontinence every 2 hours.</p> <p>During an interview, on 01/12/2016 at 10:52 A.M., CNA #37 indicated the resident was usually incontinent of bladder, used a bedpan on request occasionally, and was to be check and changed every couple hours.</p> <p>The January 2016 restorative documentation for Resident #103 indicated "no" was written on the documentation on 10 of 11 days of documentation. Some of the documentation for the time frames required by the care plan were left blank on 11 of 11 days. On 01/04/16, "no" was documented at 12:00 A.M. and 4:00 A.M., and there was no further documentation for the day. On 01/08/16, there was one incontinent episode documented at 5:00 A.M. In addition, it</p>			

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F 0323 SS=G Bldg. 00	<p>was unclear when "voided" and "incontinent" was documented if the resident had been provided toileting with either a bed pan or the toilet.</p> <p>3.1-41(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on observation, record review and interviews, the facility failed to ensure an assistive device was safe and adequate supervision was provided to prevent accidents with injury for 1 of 1 residents in an ambulator (Merry Walker, walker/chair combination). This deficient practice resulted in Resident #168 sustaining multiple skin tears from accidents and falls while in an ambulator. (Resident #168) B. Based on observation, record review, and interview, the facility failed to</p>	F 0323	323 Resident 168 uses the ambulator to maintain his mobility. Resident 168 has had no further incidents. Resident is monitored one on one while using ambulator for ambulation. The Physician was contacted and has not made any changes at this time to resident's medication regime. Staff were in serviced and reeducated to monitor resident while using ambulator for ambulation. Care plans and CNA assignment sheets were revised to make sure staff is present at all times when resident is using ambulator. Charts of residents	02/01/2016	

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NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527		
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	<p>provide a safe environment for residents, related to power strips that were not properly attached to the wall and had medical devices plugged into them, for 7 of 40 resident rooms observed for power strips in their room. (Room 134, 142, 143, 206, 221, 223 and 243)</p> <p>Findings include:</p> <p>A.1. Resident #168 was observed on 01/05/16 at 2:37 P.M. ambulating on the nursing unit in a merry walker restraint. Resident #168 was heard asking for a "key" and then was noted to push the Merry Walker beside a recliner and climb partially out of the Merry Walker. He was seated on the arm rest of the merry walker with his feet on the seat of the merry walker before staff intervened and assisted him out of the Merry Walker and into a recliner. However, in less than 10 minutes he was assisted back into the Merry Walker by nursing staff.</p> <p>The clinical record for Resident #168 was reviewed on 01/08/2016 10:37 A.M. Resident #168 was admitted to the facility on 06/19/15, with diagnoses, including but not limited to: Lewy body dementia, hypertension, malaise and fatigue post traumatic seizures, difficulty walking, debility, history of falls and</p>		<p>who have the potential of falls were audited; care plans and fall interventions were reviewed to ensure resident safety is maintained. Changes if any, were communicated to staff via the care guide. TL or designee will monitor residents who have fallen daily or who are at risk of falls to make sure appropriate interventions are in place for their safety. The falls committee will review residents who have recently fell and the therapy department is consulted as needed for appropriate interventions and equipment recommendations for safety. The falls committee notes will reflect these interventions and report to the DON or designee. DON or designee will submit findings to QAPI at least monthly for review, recommendation and tracking. A building survey was conducted to review the proper use of electrical connections. Medical equipment improperly plugged into power strips was changed to wall outlets. Maintenance will conduct a review of the power outlets located in resident rooms to determine if additional power outlets may be needed. This will occur at the time of resident move. Power outlets will be added when medical equipment requires more outlets. Power cords were bundled together. Staff was in-service and re-educated on the proper use of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/12/2016
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	<p>anxiety state.</p> <p>The quarterly MDS (Minimum Data Set) assessment, completed on 12/17/15, indicated the resident scored a 4 on a BIMS (Brief Interview for Mental Status) which indicated he was severely cognitively impaired. Resident #168 demonstrated physical and verbally aggressive behaviors, required limited staff assistance for bed mobility, required supervision and set up for ambulation in room, and locomotion on unit. He required extensive staff assistance for transfers, dressing, eating, toilet use, personal hygiene and bathing needs. The resident was also documented as having 1 fall without injury and two falls with injuries since his admission. The resident's weight had also decreased from 116 on admission to 99 pounds. The assessment did not indicate any restraint use.</p> <p>A potential for falls care plan, initiated on 06/19/15 and current through 03/24/16, indicated the resident was at risk for falls and injury. The interventions were as follows: staff to anticipate and meet all needs every shift, staff to assist to rest in recliner in lounge or bed between meals and activities, staff extensive 1-2 manual assist with transfers, staff to watch for decline in ADL's (Activities of Daily</p>		<p>power strips (Attachment I). The director of Environment Services will audit resident rooms daily for proper use of power strips and correct any deficiencies immediately and will notify the Nurse Team Leader on the unit or household. The director of Environmental Services will also monitor resident rooms for bundling of power cords and correct any deficiencies immediately and notify the Nurse Team Leader on the unit or household. The results of these audits will be reported via the Environmental Services(Attachment J) checklist and reported to the Administrator or designee weekly. The Administrator or designee will submit findings to QAPI at least monthly for review, recommendation, and tracking. Alleged date of compliance 2/1/2016</p>		

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	<p>Living) r/t (related to) daily use of Zyprexa (antipsychotic) , Lexapro (antidepressant), Ativan (antianxiety) and Remeron (antidepressant) and report complications to physician. Resident is increasingly confused and non-compliant, makes unexpected, sudden moves. Staff to be as watchful as possible at all times, when staff know that resident is awake, bring out of room if resident will allow or start 15 minute checks if resident doesn't want to leave room, allow resident to move around in Merry Walker when he becomes restless, watch resident when he puts his feet on the bars of the ambulator, and try to prevent him from doing so as this makes him slide off the seat, toilet resident as soon as note odor or as soon as resident becomes restless and indicated that he need to use the rest room, lock wheelchair at bedside when resident in bed to help resident have another location to sit if he should get out of bed alone, resident will be asked periodically if he has any needs, when resident is awake and restless or agitated, have him where he can be easily observed and watched. Toilet frequently. Allow resident to rest on his mattress on the floor in the lounge to better observe him and prevent falls, per family (resident's name) can be in lounge as needed for safety, resident needs to be in sight of staff if possible while awake.</p>			

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	<p>Continues to climb out of bed without help, resident may be up in ambulator when restless so that he may be able to ambulate safely, toilet prior to recliner or bed, resident at times likes to place self on floor when tired, care plan reviewed after 11/30/fall- no new interventions at this time, trial periods under close supervision out of ambulator (Merry Walker), Hospice will initiate therapy screen, go green program, may sleep on floor on mattress if resident is restless.</p> <p>A nursing note, dated 09/06/15, indicated the resident was using an "ambulator" (Merry Walker). A nursing note, dated 09/15/15, indicated the resident was complaining about the Merry walker and called it a "cage" but had experienced less falls since being placed in the ambulator.</p> <p>A fall note, dated 10/12/15 at 11:00 A.M., indicated staff heard a "thud" and found resident on the floor in the hallway with the ambulator tipped over. The resident was noted to have two abrasions to the back of his head. The note indicated the resident had been very active in the ambulator most of the day, walking and sitting with his legs up on the sides. There was no follow up action documented on the fall investigation forms.</p>			

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	<p>A fall note, dated 10/20/15 at 10:30 P.M., indicated the resident had up his feet up on the ambulator and slid out of the seat part of the ambulator and fell to the ground. The resident was not assessed to have received any injuries and there was no follow up action documented.</p> <p>A fall note, dated 11/30/15 at 12:30 P.M., indicated the resident had been in his ambulator and was later found walking in the hallway without the ambulator with blood on his hands and head. The resident received three flap type skin tears. One on the top of the head measuring 3 cm (centimeters) x (by) 2 cm. One skin tear to the left lower extremity measuring 0.8 x 1 cm. One skin tear to the left back flank area measuring 0.6 cm x 0.3 cm. There was no follow up action documented.</p> <p>A nursing note, dated 12/04/15 and 12/13/15, indicated the resident was climbing out of the ambulator and diving onto other furniture. On 12/13/15 he received two skin tears due to this action.</p> <p>A fall note, dated 12/10/15, at 10:00 A.M., indicated the resident tipped his ambulator over and fell. He sustained a "V" shaped skin tear to his left elbow measuring 2 cm. There was no follow up</p>			

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	<p>action documented.</p> <p>A fall note, dated 12/17/15, indicated the resident attempted to "dive" out of his ambulator and landed with his leg caught in the strap of the ambulator and the ambulator was turned upside down. The resident did not receive any injuries. There was no follow up action documented.</p> <p>On 12/24/15, as a result of the resident's multiple falls, including the falls from the ambulator, a screen from occupational therapy was ordered.</p> <p>During an interview, on 01/11/2016 at 10:12 A.M., LPN (Licensed Practical Nurse) #33 indicated because Resident #168 was receiving Hospice services, the Occupational Therapy screen had to be approved by the Hospice company, then contracted and completed by an Occupational Therapist of their choice. She indicated the holidays might have also delayed the intervention.</p> <p>The Occupational Therapy evaluation, completed on 01/08/16, indicated the resident was in the ambulator for part of the assessment and attempted to climb out of the ambulator. The therapist recommendations were the following: "Patient has very poor immediate</p>			

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	<p>memory recall and did not follow commands with therapist. He has days when he is apparently stronger than other days, on his weaker days he attempts to climb over the sides of furniture and he falls. There is no equipment that will provide patient with a safe environment without close staff interventions. Patient requires 24 hour close staff supervision."</p> <p>During an interview, on 12/12/16 at 10:30 A..M., LPN #33 indicated Resident #168 continued to try to climb out of his ambulator at times and the facility had discontinued the ambulator but then reinitiated the ambulator. It was unclear when this occurred and why the unsafe restraint was reinitiated. The facility assessments for the Merry Walker, completed in September, October and November 2015, did not indicate any safety issues with the device. LPN #33 indicated there was no part of any assessment utilized to determine if the restraint was a safe intervention for the resident.</p> <p>On 1/12/16 at 1:12 P.M., the Administrator provided a current policy titled, "Restraints - physical restraints", revised on 07/06, included the following: "...Policy: Restraints will only be used for the safety and well-being of the resident(s) and only after other</p>			

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	<p>alternatives have been tried unsuccessfully...."</p> <p>B.1. On 1/11/16 from 9:15 A.M.-10:00 A.M., an environmental tour was conducted of the facility with the Maintenance Director and a Maintenance employee, during which the following was observed:</p> <p>At 9:25 A.M., Resident room 206 bed W was observed with a power strip not securely attached to the wall, the plug in part of the strip was on the floor beside the residents chair. The power strip had a nebulizer machine (delivers inhalation medication) plugged into it. An interview with the Maintenance Director at this time indicated power strips were okay to use but they should not have medical equipment plugged into it.</p> <p>At 9:30 A.M., Resident room 223 bed D was observed with a power strip not securely attached to the wall, the plug in part of the strip was on the floor. The power strip had a lift chair plugged into it. An interview with the Maintenance Director at this time indicated the lift chair was plugged into the power strip because the lift chair cord would not reach the plug in on the wall.</p> <p>At 9:35 A.M., Resident room 243 bed D</p>			

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NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527
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	<p>was observed with a power strip on the floor not attached to the wall, the power strip had a lift chair plugged into it.</p> <p>At 9:40 A.M., Resident room 221 bed D was observed with a power strip draped across a bedside stand with a television and a power wheelchair charger plugged into it. An interview with the Maintenance Director at this time indicated the resident plugs his power wheelchair into the power strip daily to charge the battery for his wheelchair.</p> <p>At 9:50 A.M., Resident room 142 bed D was observed with a power strip on the floor beside the residents recliner, a metal assistive device used to pick objects up from the floor was observed tangled in the power strip cord.</p> <p>At 9:55 A.M., Resident room 143 bed W was observed with a power strip hanging from the wall plug in, the power strip was not attached to the wall and was stretched across the end of the bed. The power strip had a television and a clock plugged into it. Bed D was observed with a power strip on the floor beside the residents chair, a television was plugged into the power strip and multiple plug in cords were observed tangled around the power strip.</p>			

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F 0328 SS=D Bldg. 00	<p>At 10:00 A.M., Resident room 134 bed W was observed with a power strip on the floor not attached to the wall, multiple cords were observed tangled around the power strip.</p> <p>During an interview on 1/11/16 at 10:05 A.M., the Maintenance Director indicated the facility follows the life safety regulations regarding the use of power strips, he further indicated when he monitors resident rooms he finds medical equipment plugged into power strips.</p> <p>On 1/11/16 at 11:00 A.M., a review of the current policy titled "Fire Safety," undated, received from the Administrator indicated "...Environmental services staff will be monitoring all healthcare areas for proper use of electrical connections...Environmental staff will notify the nursing staff on their unit if medical equipment being used is not plugged into wall outlets...."</p> <p>3.1-45(a)(2) 3.1-19(c)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the</p>			

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NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527
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	<p>following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview and record review, the facility failed to ensure nebulizer inhalation treatments were conducted under the supervision of licensed staff for 1 of 2 residents reviewed for respiratory treatments. (Resident #68)</p> <p>Finding includes:</p> <p>On 11/7/16 at 10:25 A.M., RN (Registered Nurse) #1 was observed administering medications to Resident #68. The medication, a budesonide (corticosteroid) vial containing 0.5 milligrams/2 milliliters was placed into the medication dispenser and a face mask was positioned over the resident's nose and mouth. The nebulizer machine was turned on to dispense the Budesonide medication by the inhalation method, using a nebulizer machine. The resident's breath sounds, pulse or oxygen level (SATS) were not assessed prior to the resident receiving the inhalation medication. The resident was positioned in front of a TV (Television) and RN #1</p>	F 0328	<p>328 Resident 68 continues with nebulizer treatment. Staff will remain near the resident while the treatment is being administered. Staff will encourage cough and deep breathing, assess lung sounds, and oxygen saturation before and after the treatment and record in the ETAR. Charts were reviewed to determine if residents were able to self administer nebulizer treatments. Care plans were updated to reflect the ability to self-administer nebulizer treatments. The policy was reviewed and revised to indicate staff should remain near the resident while the treatment is being administered and to conduct a respiratory assessment before and after the treatment (Attachment K). Staff was in-serviced and re educated on the updated policy (Attachment L). Chart audits will be conducted to ensure proper documentation is completed in the ETAR by the NTL or designee. The NTL or designee will monitor compliance with remaining near the resident on daily rounds. Immediate staff redirection will occur as</p>	02/02/2016
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	<p>walked out of the room while the nebulizer machine dispensed the medication. RN #1 indicated she would return in 10-15 minutes to check on the resident when the treatment was completed.</p> <p>On 11/7/15 at 10:44 A.M., RN #1 was observed going back into Resident #68's room, she removed the face mask and placed the entire mask with the dispenser and oxygen tubing attached on the top of the nebulizer machine. The nurse then walked out of the room without assessing the effectiveness of the nebulizer inhalation treatment.</p> <p>During an interview, on 1/7/16 at 3:30 P.M., the Director of Nursing (DON) indicated the facility's policy did not require a nurse to stay in the room and observe the resident during the administration of a nebulizer respiratory treatment. He further indicated the facility was not capturing on the Minimum Data Set (MDS) assessment, respiratory treatments. The DON provided a policy titled "Oxygen Therapy-Nebulizer Treatment", dated 7/06, and indicated the policy was the one currently used in the facility. The policy indicated "...4. Dispense prescribed amount of medication into med trap. 5. Turn machine on and place</p>		<p>necessary. Findings of the chart audits and daily rounds will be reported to the DON or designee via the Healthcare report sheet (Attachment C). The DON will report findings to QAPI at least monthly for review, recommendations, and tracking. Alleged date of compliance 2/2/2016</p>		

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	<p>face mask on resident and leave in place until medication has been dispersed. 6. After treatment, remove mask, and rinse med trap... 10. Observed resident for any adverse reaction and inform physician if necessary...."</p> <p>A nebulizer policy was requested from the facility's pharmacy and was received from the DON on 1/7/16 at 3:30 P.M. A policy titled "Nebulizer/Compressor Procedure", dated January 2007, indicated "...E. Place med/meds in nebulizer F. Have patient sit up G. Turn machine on... I. Have patient inhale slow deep breaths, holding briefly and exhale slowly J. Treatment is finished when all medication is used. K. After treatment turn off machine. L. Do not leave med in nebulizer from one treatment to the next. M. Change tubing weekly. N. QMA's may not do nebulizer treatments...."</p> <p>On 1/11/16 at 11:00 A.M., a review of the clinical record for Resident #68 was conducted. The resident's diagnoses included but were not limited to: chronic airway obstruction, asthma and dementia.</p> <p>A Medication Self-Administration Assessment, dated 12/30/10, indicated the resident did not wish to administer her own medications.</p>			

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	<p>An Annual Minimum Data Set (MDS) Assessment, dated 12/17/15, indicated the resident Brief Interview Mental Status (BIMS) score was a 3. A BIMS score between 0-7 indicated the resident had severe dementia.</p> <p>A Cognitive Loss/Dementia careplan, dated 2/9/15, indicated the resident exhibits severely impaired cognitive functioning as evidenced by her inability to stay awake, minimal to no verbal responses and sleeping much of the time.</p> <p>During a telephone interview, on 1/11/16 at 2:02 P.M., the facility's pharmacist indicated if the physician requested to have the resident assessed before/after a nebulizer treatment the pharmacy would add those directions to the Medication Administration Record (MAR) or if the facility's policy indicated those assessments were to be completed. The facility's pharmacist further indicated a resident who had poor cognition should not be left in the room by him or herself during the respiratory/nebulizer treatment.</p> <p>During an interview, on 1/11/16 at 2:35 P.M., the DON indicated the facility's policy did not indicate the resident needed to be observed during the nebulizer respiratory treatment.</p>			

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NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527
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F 0329 SS=D Bldg. 00	<p>A manual located at the nursing desk titled "Illustrated Manual of Nursing Practice," 2nd edition, copyright 1993, indicated on page 419 "...Aerosols should be used cautiously in patients susceptible to fluid accumulation and atelectasis, especially those with CHF [congestive heart failure], respiratory distress, or a depressed cough reflex. Because they can precipitate bronchospasm, aerosols should also be given cautiously to asthmatic patients...After an aerosol treatment...Evaluate the effectiveness of therapy by comparing current breath sounds with pretreatment findings...." The manual further indicated on page 420, if the patient is receiving nebulizer treatment "...watch him for bronchospasm and dyspnea. Stay with him for the duration of the treatment (usually 15-20 minutes)... take the patient's vital signs before treatment begins and monitor...."</p> <p>3.1-47(a)(6)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/12/2016
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	<p>from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure Gradual Dose Reductions (GDR's) were completed timely and the facility also failed to ensure residents had adequate indications to support the use of an antianxiety and antipsychotic medications for 2 of 5 residents reviewed for unnecessary medications. (Resident #55 and Resident #161)</p> <p>Findings include:</p> <p>1. On 1/11/16 at 10:30 A.M., a review of the clinical record for Resident #55 was conducted. The record indicated the</p>	F 0329	329 On 1/23/16 a dose reduction of Ativan was completed on Resident #55. Resident has not had any clinical changes. The psychiatrist was contacted regarding a dose reduction of Abilify on Resident #161. The Abilify was reduced to 2 mg daily on 2/1/2016. Charts of residents on psychoactive drugs were reviewed for compliance with gradual dose reduction requirements and proper diagnosis to support the use of medications. The procedure for pharmacy recommendations was reviewed and updated. Recommendations will be faxed to the physician for recommendations and a rationale	02/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 01/12/2016
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527		
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	<p>resident was admitted on 10/21/13. The resident's diagnoses included but were not limited to: depressive disorder.</p> <p>The January 2016 Medication Administration Record (MAR) indicated the resident's medication list included but were not limited to: Ativan (antianxiety) 0.5 mg (milligrams) twice a day (BID) for major depressive disorder.</p> <p>A Quarterly Minimal Data Set (MDS) assessment, dated 11/26/15, indicated the resident's Brief Interview Mental Status (BIMS) score was 15 (normal cognition), and resident had no behaviors. The assessment further indicated the resident had received an antianxiety medication 7 days a week.</p> <p>A Level II: Mental Health Assessment, dated 11/11/13, indicated the resident was taking Wellbutrin SR 150 mg BID (start date 7/29/13), Remeron 30 mg at HS (start date 10/29/13) and Ativan 0.5 mg BID (start date 10/29/13). The form further indicated the resident was taking all three medications for depression.</p> <p>A review of the pharmacy recommendations for 2015, indicated there had been no recommendations to lower the dose of the antianxiety medication Ativan.</p>		<p>for declination of changes. If a response is not received in one week, the NTL or designee refax the recommendation and will contact the physician office by phone for follow-up. Recommendations not addressed within two weeks of receipt will be discussed with the Medical Director for advice and recommendations. The NTL were in-serviced and re-educated on the procedure (Attachment M). Pharmacy recommendations not addressed within the two week time frame will be reported to the DON or designee via the healthcare report sheet (Attachment C). The DON or designee will report findings to QAPI at least monthly for review, recommendation, and tracking. Alleged date of compliance 2/2/2016</p>		

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	<p>A careplan indicated the resident had the potential for functional decline, mental changes, falls and other side effects related to use of Ativan daily for major depression. The interventions included but were not limited to: observe for adverse side effects, document/report, assessment for signs of involuntary movements and resident will receive lowest therapeutic dose for control of symptoms.</p> <p>On 1/11/16 at 12:30 P.M., the Director of Nursing provided a policy titled " Medication - Antipsychotic Drug Reduction," dated 7/06, and indicated the policy was the one currently used by the facility regarding anti-anxiety medications. The policy indicated "...Residents who use antipsychotic drugs must receive dose reductions, or behavioral programming, unless clinically contraindicated in an effort to ensure lowest effective dose is being utilized...."</p> <p>During an interview, on 1/11/16 at 2:15 P.M., Social Service Assistant #2 for the Vista unit, indicated the resident had not had a reduction of her Ativan since her admission. She further indicated the resident was taking the Ativan for depression and there would be no</p>			

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	<p>behavior notes documenting anxiety for the resident.</p> <p>2. On 1/8/16 at 2:49 P.M., record review indicated, Resident #161 was admitted to the facility on 7/3/15, with diagnosis including, but were not limited to, "...hypertension, depressive disorder, anxiety, mood disorder and constipation..."</p> <p>A physician order, dated 12/4/14, indicated the resident was on Buspirone (given for anxiety) 15 mg (milligrams) TID (three times daily). A physician order, dated 3/2/15, indicated the resident was on Abilify (an antipsychotic) 5 mg 1/2 tab daily.</p> <p>An admission MDS (Minimum Data Set) assessment, completed on 7/16/15, indicated Resident #161 was cognitively intact with a BIMS (Brief Interview for Mental Status) score of 14.</p> <p>A psychiatric center physician visit form, dated 7/27/15, indicated mood and behavior appear to be fairly stable recently. No major behavioral difficulties reported recently. It would be helpful to have some nursing notes regarding his behavior at the time he is seen.</p> <p>A medication review for mood/behavior, dated 9/9/15, indicated the resident had</p>			

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	<p>one incident of verbal abuse in August, overall he had not exhibited behaviors.</p> <p>A psycho-social assessment, dated 10/24/15, indicated Resident #161 was on Abilify for depression and Buspar for depression with anxiety. The form further indicated no physical or verbal behavior towards others was exhibited and staff had not noted any mood symptoms in their charting.</p> <p>A medication review for mood/behavior, dated 10/30/15, indicated staff noted no mood or behavioral symptoms in nursing notes. Staff reported resident's mood appeared more pleasant and he had more positive verbal statements.</p> <p>A medication review for mood/behavior, dated 11/12/15, indicated staff noted no mood or behavior symptoms in nursing notes. Nursing was to request a review of the Abilify at resident's next psychiatrist visit on 12/22/15, as resident's primary physician would like the anti-psychotic discontinued before reviewing the option of decreasing the Buspar.</p> <p>Interdisciplinary notes, dated 11/5/15, 11/12/15, 11/19/15, 11/28/15, 12/17/15, 12/25/15 and 12/31/15, indicated no behaviors were noted.</p>			

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	<p>A pharmacy recommendation, dated 11/29/15, indicated "...his Abilify was last reduced from 5 mg qd [daily] to 2.5 mg qd in November 2014. He is due for consideration for reduction for his psychotropic medications. Would [resident name] be a candidate to reduce Abilify to 2 mg qd?...." There was no physician response indicated on the pharmacy recommendation.</p> <p>A psychoactive and sedative/hypnotic utilization by resident report, dated 12/30/15, indicated the resident was taking Abilify 2.5 mg qd, major depressive disorder was not listed under the dx (diagnosis) list, only depressive disorder. On 3/24/15, nurse will try to clarify dx to mood disorder resident would be seen by psychiatric center next appointment 12/22/15.</p> <p>A psychiatric center physician visit form, dated 12/22/15, indicated denies severe depression. Mood and behavior appear to be remaining stable. No major behavioral difficulties reported recently.</p> <p>During an interview, on 1/1/16 at 2:35 P.M., the Social Service Director indicated the resident was taking the Abilify for aggression which he had not had for a long time. She further indicated he had been stable and had not had any</p>			

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	<p>behaviors the last few months. The Social Service Director indicated the resident's medications were reviewed during his behavior/mood meeting in November, and it was recommended that nursing request a review of the Abilify dose at the residents next psychiatrist visit on 12/22/15. She was unsure why the dose was not reduced as recommended.</p> <p>On 1/11/16 at 3:34 P.M., review of a care plan, initiated on 5/12/14, indicated the problem: I am at risk for complications r/t (related to) routine use of Prozac, Remeron for depression and Buspar and Abilify for anxiety with mood disorder. Interventions included but were not limited to "...behavior team meets periodically to discuss current med regime and need for dose reduction or elimination of med and report to phys [physician]...."</p> <p>On 1/11/16 at 3:40 P.M., a review of the current policy titled "Medication-Antipsychotic Drug Reduction" received from the Social Service Director indicated "...1. The facility's drug reduction plan shall include the following measures:...Gradual dose reduction: A program that consists of tapering the resident's daily dose to determine if the resident's symptoms can be controlled by a lower dose, or to</p>			

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F 0425 SS=D Bldg. 00	<p>determine if the dose can be eliminated altogether...3. The resident's physician provides a justification why the continued use of drug and the dose of the drug is clinically appropriate. The justification shall include: a. Diagnosis, but not simply a diagnostic label or code, but the description of symptoms. b. Discussion of why the present dose is necessary to manage the symptoms of the resident. This information shall be a part of the resident's clinical record...."</p> <p>3.1-48(a)(6)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p>			

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	<p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview and record review, the facility failed to ensure 1 of 5 medication carts and 1 of 7 medication rooms reviewed were free from expired medications.</p> <p>Findings include:</p> <p>During a medication cart and medication room review conducted on 01/12/2016 from 10:54 A.M. to 11:26 A.M., the following was found:</p> <p>Polyethylene glycol (a stool softener) with an expiration date of 12/21/2014, in a medication cart on Vista Hall.</p> <p>Mary's Magic Mouth Wash, with an expiration date of 12/30/2015, in the refrigerator located in the medication room on Lea Hall.</p> <p>On 01/12/2016 at 2:15 P.M., LPN (Licensed Practical Nurse) #33 provided a policy titled "MEDICATION STORAGE IN THE FACILITY," dated 01/2007, and indicated it was the current policy used by the facility. The policy indicated "...M. Outdated, contaminated, or deteriorated medications and those in</p>	F 0425	<p>425 Medication carts were audited for expired and discontinued medications, these were removed if present. The pharmacy provides a technician to audit medication carts monthly for expired or discontinued medications any deficiencies are reported to the DON via Medication Room and Cart Inspection Report (Attachment N). Nurses were in-serviced and re-education to remove discontinued medications from the medication cart when orders are discontinued (Attachment O). Night shift nurses will audit medication carts on Wednesday night for expired and discontinued medications and remove items immediately (Attachment P). The results of this audit will be reported to the NTL. The NTL will report the findings to the DON or designee weekly via healthcare report sheets(Attachment C). The DON or designee will review the pharmacy report and provide education and redirection as necessary on the procedure for the disposal of expired or discontinued medications. Findings will be reported to QAPI at least bi weekly for review, recommendation, and tracking. Alleged date of compliance 2/2/2016</p>	02/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/12/2016
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F 0441 SS=D Bldg. 00	<p>containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal (see Section IE: DISPOSAL OF MEDICATIONS AND MEDICATION-RELATED SUPPLIES), and reordered from the pharmacy (see IC3: ORDERING AND RECEIVING MEDICATIONS FROM THE DISPENSING PHARMACY), if current order exists...."</p> <p>3.1-25(o)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and</p>			

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	<p>corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and interview, the facility failed to ensure a nebulizer medication trap/reservoir was cleansed after each use and stored in a plastic bag for 2 of 2 residents observed during a medication inhalation administration. (Resident #160 and Resident #68)</p> <p>Findings include:</p> <p>1. On 1/7/16 at 8:55 A.M., LPN (Licensed Practical Nurse) #3 was observed obtaining a nebulizer mask from a compartment in the nebulizer machine, placing medication in the medication trap/reservoir and starting the nebulizer treatment for Resident #160.</p>	F 0441	<p>441 Nebulizer equipment for residents #160 and #68 were cleaned and placed in a plastic bag. Nebulizer equipment for all residents with orders for nebulizer treatments were cleaned and placed in a plastic bag. The Nebulizer treatment policy was reviewed and updated (Attachment K). Staff was in-serviced and re-educated on the proper procedure for cleaning and storing nebulizer equipment (Attachment L). NTL or designee will monitor compliance with cleaning and bagging of equipment on daily rounds any deficiencies will be corrected immediately. This will be reported to the DON or designee via the healthcare report sheets</p>	02/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/12/2016	
NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527			
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	<p>The compartment where the mask was removed had hair and other debris lying in the area where the mask had been stored. LPN #3 indicated she would clean the compartment out after the treatment was completed. At 9:09 A.M., LPN #2 was observed removing the mask and placing the mask on a hook, on the nebulizer machine, without cleansing the medication trap/reservoir.</p> <p>During an interview, on 1/7/15 at 9:33 A.M., the Director of Nursing (DON) indicated the nebulizer mask and medication trap/reservoir were to be stored in a zip lock plastic bag. The bag and its contents were to be changed weekly.</p> <p>2. On 1/7/16 at 10:29 A.M., the nebulizer mask and medication reservoir for Resident #68 was observed lying on the resident's recliner. RN (Registered Nurse) #1 placed the inhalation medication in the medication reservoir and placed the mask on the resident to begin the respiratory treatment. At 10:45 A.M., RN #1 removed the nebulizer mask, with the medication dispenser, from the resident's face and placed the mask and reservoir (containing scant amount of medication still in the reservoir) onto the nebulizer machine without rinsing out the medication</p>		(Attachment C). DON or designee will report findings to QAPI at least monthly to QAPI for review, recommendation, and tracking. Alleged date of compliance 2/2/2016				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/12/2016
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	<p>reservoir.</p> <p>On 1/7/16 at 11:00 A.M., the DON provided a policy titled "Oxygen Therapy-Nebulizer Treatment", dated 7/06, and indicated the policy was the one currently used by the facility. The policy indicated "... 6. After treatment, remove mask and rinse med trap...8. Store O2 sets in bags...."</p> <p>On 1/7/16 at 3:30 P.M. the DON provided a policy from the facility's pharmacy titled " Nebulizer/Compressor Procedures", dated January 2007. The policy indicated "...L. Do not leave med in nebulizer from one treatment to the next."</p> <p>3.1-18(a)</p>				